

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3381

CERTIFICATE OF DEATH

Reg. Dist. No. 03365

1. PLACE OF DEATH a. COUNTY <u>HARTFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARTFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>5 1/2 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARTFORD Memorial</u>		d. STREET ADDRESS <u>Bush Chapel Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Joseph</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 June 1957</u>
9. AGE (In years last birthday) <u>9</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Dwight Adams</u>		14. MOTHER'S MAIDEN NAME <u>Thelma Vesely</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>** **</u>	
17. INFORMANT <u>James D. Adams</u>		Address <u>R.D. #1, Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, diffuse, both lungs</u> DUE TO (b) <u>491x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>48 hr</u> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-23-</u> , 19 <u>58</u> , to <u>5-23-</u> , 19 <u>58</u> that I last saw the deceased alive on <u>5-23-</u> , 19 <u>58</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city, or town, state) <u>8 Low St. Aberdeen, Md.</u> DATE SIGNED <u>3-24-58</u>			
ACTUAL SIGNATURE <u>Peter P. Rodman</u>		M.D. <u>Peter P. Rodman, M.D.</u>	
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>		<u>Aberdeen, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Fanning</u>		ADDRESS <u>Aberdeen, Md.</u>	
24a. REC'D BY REGISTRAR <u>W. H. Beach</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	
DATE <u>MAR 27 58</u>			

CERTIFICATE OF DEATH

25 June 1957

Deceased

John Doe

Age 45

BUREAU V. S.

MAR 27 1958

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3401 **CERTIFICATE OF DEATH**

03367

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		STATE <u>MARYLAND</u>		COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>RURAL - BEL AIR</u>		LENGTH OF STAY (in this place) <u>20 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BEL AIR</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD BEL AIR</u>				STREET ADDRESS (If rural give location) <u>NEAR HICKORY</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>EFFIE</u> <u>ALA</u> <u>ANDERSON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH</u> <u>4</u> , 19 <u>58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Wid</u>	8. DATE OF BIRTH <u>JUNE 18, 1889</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Newton BLEVINS</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>ELMER R ANDERSON, BELAIR, MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
170X IMMEDIATE CAUSE (A) <u>BRONCHOPNEUMONIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 or 4 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>METASTATIC CARCINOMA in Lung and pleura</u>						<u>6 to 8 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>CARCINOMA of BREAST</u>						<u>5 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>NOV. 28</u> , 19 <u>52</u> , to <u>MAR. 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MARCH 3</u> , 19 <u>58</u> , and that death occurred at <u>8:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul A. Stoner</u>		ADDRESS (Street, city, town, state) <u>M.D. 115 FULFORD AVE., BEL AIR MD</u>		DATE SIGNED <u>3/4/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/7/58</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Spring Baptist</u>		LOCATION (City, town, or county) (State) <u>LANCASTER GA</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Paul A. Stoner</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u>		ADDRESS <u>Bel Air, MD</u>	
DATE <u>MAR 7 '58</u>							

CERTIFICATE OF DEATH

Form 100-100

1. Name of deceased (Print or write full name)

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Cause of death

8. Date of death

9. Time of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of funeral director

15. Signature of undertaker

16. Signature of cemetery

17. Signature of burial place

18. Signature of interment

19. Signature of burial

20. Signature of burial

21. Signature of burial

22. Signature of burial

23. Signature of burial

24. Signature of burial

25. Signature of burial

26. Signature of burial

27. Signature of burial

28. Signature of burial

29. Signature of burial

30. Signature of burial

31. Signature of burial

32. Signature of burial

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43. Signature of burial

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45. Signature of burial

46. Signature of burial

47. Signature of burial

48. Signature of burial

49. Signature of burial

50. Signature of burial

BUREAU V. S.

MAR 7 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3382

CERTIFICATE OF DEATH

Reg. Dist. No. 3368

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>25 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1400 S. MAIN ST.</u>	
3. NAME OF DECEASED (Type or print) <u>W. Sanner</u> First <u>Boiley</u> Middle <u>Boiley</u> Last		4. DATE OF DEATH <u>March 18</u> Month <u>18</u> Day <u>1958</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumber Mill Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>	11. BIRTHPLACE (State or foreign country) <u>Churchville, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thomas V. Bailey</u>	
14. MOTHER'S MAIDEN NAME <u>Sallie J. Schultz</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>7-20-18-7042</u> <u>219-28-9959</u>		17. INFORMANT <u>Mrs. Hattie V. Bailey</u> Address <u>400 S. Main St., Bel Air, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-18</u> , 19 <u>58</u> , to <u>3-18</u> , 19 <u>58</u> , that I lost saw the deceased alive on <u>3-18</u> , 19 <u>58</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u> DATE SIGNED <u>3-18-58</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>March 21, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph William Foster</u> ADDRESS <u>W. Broadway BEL AIR, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 20 58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Sanner</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

BURKAW W. B.

MAR 20 1958

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3402 CERTIFICATE OF DEATH

Reg. Dist. No. 03369

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural. ROCKS</u>		LENGTH OF STAY (in this place) <u>7 mo</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bayman</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ROCKS OF DEER CREEK REST HOME</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>NANCY</u> (First) (Middle) (Last) <u>BOYER</u>				4. DATE OF DEATH <u>MARCH 1</u> 19 <u>58</u> (Month) (Day) (Year)			
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, <u>MARRIED</u> , WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>JULY 27, 1928</u>	9. AGE last birthday <u>29</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Harford, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard C. Spuniger</u>				14. MOTHER'S MAIDEN NAME <u>Florence Carpenter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Wm. W. Boyer, Bayman, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
345x IMMEDIATE CAUSE (A) <u>PNEUMONIA</u>						2 DAY	
ANTECEDENT CAUSE(S) DUE TO (B) <u>INCREASING SPASTIC PARALYSIS AND ULCERS</u>						1 YR.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>MULTIPLE SCLEROSIS</u>						OVER 5 YRS	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>493x</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 15, 1957</u> , to <u>March 1, 1958</u> , that I last saw the deceased alive on <u>Feb. 26, 1958</u> , and that death occurred at <u>10:55 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Philip W. Dorman</u>		M.D. <u>307 HICKORY, BELAIR, Md</u>		DATE SIGNED <u>MARCH 1, 1958</u>			
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/4/58</u>		NAME OF CEMETERY OR CREMATORY <u>Spurston</u>		LOCATION (City, town, or county) (State) <u>Bayman, Md.</u>	
24. REC'D BY REGISTRAR <u>MAR 6 '58</u>		REGISTRAR'S SIGNATURE <u>W. Beach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William W. Boyer</u>		ADDRESS <u>Harford, Md.</u>	

CERTIFICATE OF DEATH

File No.

1. Name of Deceased

2. Sex

3. Age

4. Date of Birth

5. Place of Birth

6. Date of Death

7. Place of Death

8. Cause of Death

9. Manner of Death

10. Signature of Physician

11. Signature of Registrar

12. Signature of Coroner

13. Signature of Medical Examiner

14. Signature of Pathologist

15. Signature of Forensic Physician

16. Signature of Medical Officer of Health

17. Signature of Health Officer

18. Signature of Sanitary Officer

19. Signature of Registrar

20. Signature of Coroner

21. Signature of Medical Examiner

22. Signature of Pathologist

23. Signature of Forensic Physician

BURKAY Y. E.

MAR 6 1938

RECEIVED

1

INSTRUCTIONS

TO ATTEND PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

03370

Reg. Dist. No.

3423

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY OR TOWN <u>Rural Bel Air</u>		LENGTH OF STAY (in this place) <u>3 years</u>		CITY OR TOWN <u>Bel Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescent Home</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>SALAH Elizabeth</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>March 3 1958</u> (Month) (Day) (Year)			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widow</u>		8. DATE OF BIRTH <u>June 21, 1885</u>	
9. AGE last birthday <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Daughton</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Nixon Kelly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-18-63404</u>		17. INFORMANT & ADDRESS <u>Mrs. George E. Geyer 3113 Abell Ave. Balto. Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						Sudden	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C) <u>Hypertensive cardio-vascular disease</u>						8 years	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1, 1948</u> , to <u>March 3, 1958</u> , that I last saw the deceased alive on <u>March 2, 1958</u> , and that death occurred at <u>10:00A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>William P. Hudson</u>				DATE SIGNED <u>March 3, 1958</u>			
ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 6 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Centre</u>		LOCATION (City, town, or county) (State) <u>Forest Hill Md.</u>	
24. REC'D BY REGISTRAR <u>Al Hudson</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Martin R. Davis</u>		ADDRESS <u>Md.</u>	
DATE <u>MAR 10 1958</u>							

BUREAU V. 5

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REVISED

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

RECEIVED

MAR 17 1958

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 03372

1. PLACE OF DEATH Harford		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Aberdeen Proving Grounds		d. STREET ADDRESS 47 Aberdeen Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles W Clark		4. DATE OF DEATH March 8 1958	
5. SEX Male	6. COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1909
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Chief		10b. KIND OF BUSINESS OR INDUSTRY Fire Department	
11. BIRTHPLACE (State or foreign country) Earlville, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME James H. Clark		14. MOTHER'S MAIDEN NAME Gertrude VanDyke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO.	
17. INFORMANT Ralph Clark		Address 16 Fairview Avenue, Pennsville, NJ	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cause Unknown (DOA) Presumably due to coronary 911.6 DUE TO occlusion while fighting a fire Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 2 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) was inspecting the site of a fire for origin of fire 11:30 p.m. earlier had been exposed to smoke inhalation & had to leave	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 1135 Mar 8 1958	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Building 3125	20f. (City or town) (County) (State) Aberdeen Proving Grounds Md.
21. I certify that I attended the deceased from 8 March 1958 to March 8 1958 , that I last saw the deceased alive on 12 and that death occurred at 1130 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William M. Michener M.D. Army Hospital, Aberdeen Prov Gd, Md. Mar 9, 1958			
ACTUAL SIGNATURE William M. Michener			
PHYSICIAN'S NAME (Type) William M. Michener Capt MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-11-58	22c. NAME OF CEMETERY OR CREMATORY CHESTER CEMTY	22d. LOCATION (City, town, or county) (State) CHESTERTOWN, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Victor H. Kennedy		ADDRESS STILL POND, MD.	24a. REC'D BY REGISTRAR DATE MAR 11 1958
		24b. REGISTRAR'S SIGNATURE W. H. Kennedy	

Page 4

THE LOW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH. THE ATTENDING PHYSICIAN, THE HOSPITAL OR OFFENDING PHYSICIAN, MAY BE RELIED UPON BY THE REGISTRAR. AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN, THE REGISTRAR SHOULD BE FILLED WITH PAGE 3 SHOULD BE DETACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. THEN PLEASE REMOVE CARBON PAPERS. PAGES 1 AND 2 SHOULD BE FILLED WITH THE REGISTRAR PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT WITHIN 72 HOURS AFTER DEATH.

BUREAU V. S.

11 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03373

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>50</u> <u>mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> <u>Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D. 2</u>				d. STREET ADDRESS <u>R.D. # 2</u>			
3. NAME OF DECEASED (Type or print) First <u>Arscena</u> Middle <u>Cooper</u> Last <u>Cooper</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>June, 16, 1898</u>		9. AGE (In years last birthday) <u>59</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.,</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Chambers</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Elize Cooper, Bel Air R.D. #2 Maryland.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Bel Air Md</u>			
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 5, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u>			
22d. LOCATION (City, town, or county) <u>Churchville</u>		22e. (State) <u>Harford, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard McEwen Jr</u>			
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>MAR 5 '58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JEAN V. S.

2 2 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3384

CERTIFICATE OF DEATH

Reg. Dist. No. 03374

1. PLACE OF DEATH a. COUNTY <u>Harford Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. <u>Harford</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abideon</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abideon</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>136 Balto. Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Jennie Lee Daugherty</u> First Middle Last		4. DATE OF DEATH <u>3/16/58</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/30/1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	
11. BIRTHPLACE (State or foreign country) <u>Rock Run Harford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. S. Lee</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Peaco</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Wm. Orsey</u>		136 Balto. Ave. Address <u>Abideon Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Cervix</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>171X</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 10, 1957</u> , to <u>March 26, 1958</u> , that I last saw the deceased alive on <u>March 25, 1958</u> , and that death occurred at <u>5:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>509 Revolution St., Harford Grace Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>3/28/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3/29/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Spring</u>	22d. LOCATION (City, town, or county) (State) <u>Level Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sam. Harrell</u>		ADDRESS <u>Harrell Harrell, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Reed Leach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 1 1962

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3385 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Item 4 FilmG226 3-13-58 et

03375

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harrisford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harrisford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisford Grace</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harrisford Memorial Hospital</u>		d. STREET ADDRESS <u>Old Port Road</u>	
3. NAME OF DECEASED (Type or print) <u>George Finkernagel</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 18, 1896</u>
9. AGE (In years last birthday) <u>61</u> yrs		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or at retirement) <u>Plumber Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Finkernagel</u>		14. MOTHER'S MAIDEN NAME <u>Anna</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>215-09-5132</u>	
17. INFORMANT <u>Geo Finkernagel Jr - Harrisford Grace</u>		Address <u>see</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture L.T. b.i.e</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Auto accident auto pedestrian type</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> p.m. <u>3-2-58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Old Port Road</u>		20f. (City or town) <u>Aberdeen</u> (County) <u>Harrisford</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE OF THE DEED <u>3/5/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Harrisford Grace Md.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Sarring</u>		24. REC'D BY REGISTRAR <u>see</u>	
24b. REGISTRAR'S SIGNATURE <u>see</u>		DATE <u>MAR 6 1958</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 6 1953

RECEIVED

3406

CERTIFICATE OF DEATH

03376

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rocke</u>		c. LENGTH OF STAY IN 1b <u>48 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rocks (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Oleita Baker Flowers</u>				4. DATE OF DEATH Month Day Year <u>March 27 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 23 1906</u>		9. AGE (In years last birthday) yrs <u>52</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hartford, Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Baker</u>				14. MOTHER'S MAIDEN NAME <u>Oliza Amos</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-183040</u>		17. INFORMANT Address <u>Howard Flowers - Rocks Rd Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4 hrs</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 Jan</u> 195 <u>6</u> , to <u>27 MAR</u> 195 <u>8</u> , that I last saw the deceased alive on <u>13 MAR</u> 195 <u>8</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>The A.E. Moseley Jr.</u> M.D. <u>7</u> <u>28 MAR 1958</u> PHYSICIAN'S NAME (Type) <u>JARRETTSVILLE MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-29-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Beltair Hartford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Madam E. K. ...</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

1938

RECEIVED

CERTIFICATE OF DEATH

3407

Item 1 FilmG227 3-28-58 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>		LENGTH OF STAY (in this place) <u>6 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Private home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>James</u> (Middle) <u>E.</u> (Last) <u>Grace</u>				(Month) <u>March</u> (Day) <u>13</u> (Year) <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 19, 1886</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bairy</u>		11. BIRTHPLACE (State or foreign country) <u>Ash Co. M.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David L. Grace</u>				14. MOTHER'S MAIDEN NAME <u>Malinda E. Proffett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>216-10-0833</u>		17. INFORMANT & ADDRESS <u>Mrs. Gamu E. Grace</u> <u>Darlington, Md.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						<u>27 hours</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C) <u>Chronic cardio-vascular disease</u>						<u>10 years</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic bronchial asthma and emphysema.</u>						<u>30 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 5, 1958</u> to <u>March 13, 1958</u> , that I last saw the deceased alive on <u>March 13, 1958</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. S. Hudson</u>				DATE SIGNED <u>March 14, 1958</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>March 16, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Welcome Home Cem.</u>		LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u>	
24. REC'D BY REGISTRAR <u>MAR 19 '58</u>		REGISTRAR'S SIGNATURE <u>W. S. Hudson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		ADDRESS <u>Darlington, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BURIAU V. S.

MAR 18 1900

RECEIVED

TO HOSPITAL: The law requires that the decedent be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3386

CERTIFICATE OF DEATH

03378

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle May Last Gunther		4. DATE OF DEATH Month Mar. Day 28 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June, 23, 1883
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Harford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Everitt		14. MOTHER'S MAIDEN NAME Carr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Augustus Rembold, Aberdeen, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Oedema 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Pulmonary Metastasis with Infarction DUE TO (c) Carcinoma of Stomach with metastasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Disease of the Heart			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1957, to March , 1958, that I last saw the deceased alive on March 28 , 1958, and that death occurred at 1 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Frank Wolbert M.D. M.D. 220 North Union Ave. March 29, 1958 PHYSICIAN'S NAME (Type) FRANK WOLBERT MD Hanna De Grace Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 31, 1958	
22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran		22d. LOCATION (City, town, or county) (State) Joppa, Harford, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McElm...		24a. REC'D BY REGISTRAR DATE APR 1 '58	
ADDRESS Abingdon, Md.,		24b. REGISTRAR'S SIGNATURE ...	

BUREAU V. 81

1958

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3387

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03379

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> c. LENGTH OF STAY IN 1b <u>82</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Tull Gate Road</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> d. STREET ADDRESS <u>Tull Gate Road</u> e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Louise Hammond</u> First Middle Last		4. DATE OF DEATH <u>March 5</u> Month Day Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 13 1875</u> Month Day Year <u>82</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Doctor</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John W. Chambers</u>		14. MOTHER'S MAIDEN NAME <u>Alice Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> If yes, give year or dates of service		16. SOCIAL SECURITY NO. <u>L</u>	
17. INFORMANT <u>Alice Chambers</u> <u>Bel Air Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture R. Humerus + Pelvic</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Atherosclerotic C. Disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on floor</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>3:30</u> p. m. <u>58</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C. Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C. Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bel Air, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 8/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Clark's Chapel</u>		22d. LOCATION (City, town, or county) <u>Kalmar</u> (State) <u>Harford</u>	
FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u> ADDRESS <u>Bel Air Md</u>		24a. REC'D BY REGISTRAR <u>Alfred</u> 24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	
		DATE <u>MAR 7 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 7 1963

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3388 CERTIFICATE OF DEATH

Reg. Dist. No.

03380

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DEGRACE</u>				c. LENGTH OF STAY IN 1b <u>15 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GRETTA</u> Middle <u>MARIE</u> Last <u>HERING</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>23 Sept. 1903</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Brokerage</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>CARROLL HERING</u>				14. MOTHER'S MAIDEN NAME <u>BURNETTA SHIPLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 170x DUE TO <u>General Carcinoma of lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma left breast</u> DUE TO (c) <u>Terminal</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>9 mo.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8-15</u> , 19 <u>57</u> , to <u>3-10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-10</u> , 19 <u>58</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8 Law Street</u> DATE SIGNED ACTUAL SIGNATURE <u>With V. Rodman</u> M.D. PHYSICIAN'S NAME (Type) <u>Peter P. Rodman</u> M.D. <u>Aberdeen, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/13/58</u>		<u>Finksburg Cemetery</u>		<u>Finksburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u> ADDRESS <u>Aberdeen, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carroll</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 11 1912

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03381

3389

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvee de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>241 Harvee de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hosp</u>		d. STREET ADDRESS <u>201 North Stokes</u>	
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>M.</u> Last <u>HOLLAND</u>		4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 8, 1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR: Months <u>4</u> Days <u>25</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Perryman, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wesley S. Preston</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Thomas Holland</u>		Address <u>201 North Stokes Harvee de Grace, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) <u>Hypertensive Cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-31</u> , 19 <u>58</u> , to <u>3/3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/1</u> , 19 <u>58</u> , and that death occurred at <u>8:30 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>569 Revolution St., Harvee de Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>3/3/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bell</u>		ADDRESS <u>Harvee de Grace</u>	
24a. REC'D BY REGISTRAR <u>Mar 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

FAU V. S.

U. S. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3390

CERTIFICATE OF DEATH

03382

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>8 HRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>THERESA M. HOLTER</u>		4. DATE OF DEATH Month Day Year <u>MARCH 5 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1894</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. PIERCE</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Baumgart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Leo Holter,</u>		Address <u>Joppa, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation, recurrent</u> DUE TO <u>Arteriosclerotic and Hypertensive Cardio-vascular Disease</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u> <u>One Year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 4th, 1958</u> to <u>March 15th, 1958</u> that I last saw the deceased alive on <u>March 5th, 1958</u> and that death occurred at <u>6:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Koo, M.D.</u>		DATE SIGNED <u>March 5th, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Koo, M.D.</u>		ADDRESS (Street, city or town, state) <u>2411 Union Ave. Haver de Grace Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 8, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephen's</u>	22d. LOCATION (City, town, or county) (State) <u>Bradshaw, Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. M. [Signature]</u>		24a. REC'D BY REGISTRAR DATE <u>Mar 11 1958</u>	
ADDRESS <u>Abingdon, Maryland.</u>		24b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director should be notified immediately after death. The funeral director should be notified immediately after death. The funeral director should be notified immediately after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3391

CERTIFICATE OF DEATH

Reg. Dist. No. 03383

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN RFD #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>200 S. Post Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE R HOMER</u>		4. DATE OF DEATH Month Day Year <u>MARCH 3 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/14/1885</u>
9. AGE (In years last birthday) <u>73</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Singleton</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sampson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or foreign) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Viola Battle</u>		Address <u>Haure de Grace Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral a. pop. stroke</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 2, 1958</u> , to <u>March 3, 1958</u> , that I last saw the deceased alive on <u>March 3, 1958</u> , and that death occurred at <u>6:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. J. Simon</u> M.D.		ADDRESS (Street, city or town, state) <u>Haure de Grace, Md.</u>	
DATE SIGNED _____		DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>E. J. SIMON</u>		ADDRESS <u>HAURE DE GRACE, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/6/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bakers</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Carney</u>		ADDRESS <u>Aberdeen Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 10 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Richard</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

03384

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Mary Rebecca Huff</u>		4. DATE OF DEATH <u>March 5</u> 19 <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23 1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co Md</u>	
11. BIRTH PLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Edwin R. Thompson</u>		14. MOTHER'S MARDEN NAME <u>Mildred Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year of service) <u>No</u>		16. SOCIAL SECURITY NO <u>No</u>	
17. INFORMANT <u>Clare Huff</u>		Address <u>Street, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emphysema</u>			<u>8 hr</u>
2044 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Jenkenia</u>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 3, 1958</u> , to <u>March 5, 1958</u> , that I last saw the deceased alive on <u>March 3, 1958</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dorish A. Hunt</u> M.D.		ADDRESS (Street, city or town, state) <u>Leola, Pa</u> DATE SIGNED <u>3/6/58</u>	
PHYSICIAN'S NAME (Type) <u>Dorish A. Hunt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>March 9 1958</u>	<u>Harlington</u>	<u>Harford Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Harlington Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 12 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Keach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3499 CERTIFICATE OF DEATH

Reg. Dist. No.

03385

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Rural			c. LENGTH OF STAY IN 1b 15 yrs.,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen, Rural		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Calvary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle F. Last Ilgenfritz				4. DATE OF DEATH Month Mar. Day 26, Year 1958			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1871		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent		10b. KIND OF BUSINESS OR INDUSTRY Building Construction		11. BIRTHPLACE (State or foreign country) Monkton, Md.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Ilgenfritz				14. MOTHER'S MAIDEN NAME Emma Folckenmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Elizabeth M. Ilgenfritz, Aberdeen R.D. 2, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H22.1 DUE TO Central Thrombosis						9 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) Arterio-sclerotic C.V. disease	
						(c) 12 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June, 1944 to March, 1958 , that I last saw the deceased alive on March 24, 1958 , and that death occurred at St. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Ralph Horky M.D.				ADDRESS (Street, city or town, state) DATE SIGNED March 27			
PHYSICIAN'S NAME (Type) J. Ralph Horky				Churchville Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 29, 1958		22c. NAME OF CEMETERY OR CREMATORY Middletown		22d. LOCATION (City, town, or county) (State) Freeland, Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. Brown				ADDRESS Abingdon Maryland		24a. REC'D BY REGISTRAR DATE Apr 1 '58	
				24b. REGISTRAR'S SIGNATURE Al...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. E.

3392

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Starford</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Starford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Starve de Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Starve de Grace</i>	
c. LENGTH OF STAY IN 1b <i>36 yrs.</i>		d. STREET ADDRESS <i>717 S. Union Ave</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>717 S. Union Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>James H. James</i>		4 DATE OF DEATH Month <i>3</i> Day <i>5</i> Year <i>1958</i>	
5 SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 13, 1874</i>
9 AGE (In years last birthday) <i>83 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>	11 BIRTHPLACE (State or foreign country) <i>Berkeley, Maryland</i>
12 CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13 FATHER'S NAME <i>James James</i>	
14 MOTHER'S MAIDEN NAME <i>Attie ?</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>217-12-8836</i>		17 INFORMANT <i>Mrs. Myrtle James - Starve de Grace, Md.</i> Address <i>717 S. Union Ave</i>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>arterio Sclerosis - Chronic</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>hypertension</i> DUE TO (b) <i>hypertension</i> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2-20</i> , 19 <i>48</i> to <i>3-5</i> , 19 <i>58</i> that I last saw the deceased alive on <i>3-5</i> , 19 <i>58</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. L. Lewis</i> M.D.		ADDRESS (Street, city or town, state) <i>Starve de Grace, Md.</i> DATE SIGNED <i>3/4/58</i>	
PHYSICIAN'S NAME (Type) <i>A. L. Lewis</i>		<i>Starve de Grace, Md.</i>	
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-9-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Berkeley Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Washington, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William J. Bullock - Starve de Grace, Md.</i>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

6

DEAD

3410 CERTIFICATE OF DEATH

Reg. Dist. No. 03387

1. PLACE OF DEATH a. COUNTY <u>H-</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>James</u> Middle <u>Lee</u> Last <u>James</u>		4. DATE OF DEATH <u>11/10/55</u> Month <u>11</u> Day <u>10</u> Year <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1877</u>
9. AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR: Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homeowner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homeowner</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John J. James</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Hallaway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>116-174-116</u>	
17. INFORMANT <u>Geo. R. James</u> Address <u>Harford Co., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>331X</u> DUE TO (c) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-19</u> , 19 <u>55</u> , to <u>3-23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-22</u> , 19 <u>56</u> , and that death occurred at <u>5:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Lewis</u>		ADDRESS (Street, city or town, state) <u>Harford Co., Md.</u>	
PHYSICIAN'S NAME (Type) <u>A. L. Lewis</u>		DATE SIGNED <u>11/10/55</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/10/55</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harford Co., Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. B. Bailey</u> ADDRESS <u>Harford Co., Md.</u>		24a. REC'D BY REGISTRAR <u>11/27/55</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. L. Lewis</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

MAR 07 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3411 CERTIFICATE OF DEATH

03388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradise Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helena</u> Middle <u>—</u> Last <u>Karpov</u>		4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 7th 1907</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Redko</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Boris Karpov, Aberdeen #2</u>		Address <u>2nd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> 4 DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> (c) <u>Terminal</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>6 mi</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-19-</u> 19 <u>53</u> , to <u>3-8-</u> 19 <u>58</u> , that I last saw the deceased alive on <u>2-27-</u> 19 <u>58</u> , and that death occurred at <u>1:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter P. Rodman, M.D.</u>		DATE SIGNED <u>3-8-58</u>	
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>		ADDRESS (Street, city or town, state) <u>8 Law St., Aberdeen Md.</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>3/11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Carving Aberdeen Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>Mar 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Smith</u>	

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3393

CERTIFICATE OF DEATH

Reg. Dist. No. 03389

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAIRC DE PLACE</u>				c. LENGTH OF STAY IN 1b <u>18 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>E.</u> Last <u>McDonald</u>				4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 2 1879</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (carvers)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fontebell Bros.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William McDonald</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Witcomb</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO <u>216-10-0391</u>				17. INFORMANT Address <u>Wife - Box 87 - Perryman rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Hemorrhage</u> DUE TO <u>Gastric Ulcer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 1/2 yr.</u> (c)				INTERVAL BETWEEN ONSET AND DEATH <u>36 hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-26-</u> , 19 <u>58</u> , to <u>3-12-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 12</u> , 19 <u>58</u> , and that death occurred at <u>8:40 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D.				ADDRESS (Street, city or town, state) <u>840 A. M. from the causes and on the date stated above.</u>			
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman</u>				DATE SIGNED <u>3-13-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Perryman rd.</u>	
22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>				22e. (City or town) (County) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Sarring</u> ADDRESS <u>Aberdeen Md.</u>				24a. REC'D BY REGISTRAR <u>3-13-58</u>			
24b. REGISTRAR'S SIGNATURE <u>Witcomb</u>				DATE <u>MAR 17 '58</u>			

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU N. E.

MAR 17 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03390

3394

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford de Grace		c. LENGTH OF STAY IN TB 32 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford de Grace	
		d. STREET ADDRESS 839 ONTARIO	
3. NAME OF DECEASED (Type or print) James First McEwing Middle McEwing Last		4. DATE OF DEATH March 4 1958 Month 4 Day 1958 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 31, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business Executive		10b. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (In years last birthday) 80 yrs.
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME LEVANIL V. McEWING		14. MOTHER'S MAIDEN NAME ANNIE CORNELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 216-05-3716	
17. INFORMANT Wm. Allen Kimball Address HARFORD DE GRACE MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 4 d. d. 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) Chronic Myocarditis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 3 , 19 57 , to March 4 , 19 58 , that I last saw the deceased alive on 3-4 , 19 58 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. F. Lewis, M.D.		DATE SIGNED March 4 1958	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAR. 7, 1958	22c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM	22d. LOCATION (City, town, or county) (State) HARFORD DE GRACE MD
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell ADDRESS Harford de Grace MD		24a. REC'D BY REGISTRAR DATE MAR 6 '58	24b. REGISTRAR'S SIGNATURE W. H. Lewis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

MAR 6 1938

RECEIVED

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3395

CERTIFICATE OF DEATH

Reg. Dist. No.

03391

1. PLACE OF DEATH a. COUNTY HARTFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARTFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Havre de Grace (Rural)			
c. LENGTH OF STAY IN 1b 3 hrs.				d. STREET ADDRESS RD #1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hartford Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert First Byrd Middle Miller Last				4. DATE OF DEATH March Month 5 Day 1958 Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 23, 1950	
9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR: Months 7 Days 1 Hours 1 Min 1		IF UNDER 24 HRS: Months 7 Days 1 Hours 1 Min 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME David R. Miller Jr.				14. MOTHER'S MAIDEN NAME Glenn May Lichtenstein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT David R. Miller Jr. R.D. 1 Havre de Grace, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO Rupture of basilar artery aneurysm Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 20 hrs.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from March 5 , 19 58 , to March 6 , 19 58 , that I last saw the deceased alive on 19 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Havre de Grace, Md. DATE SIGNED THEODORE H. KAISER							
ACTUAL SIGNATURE Theodore H. Kaiser M.D.							
PHYSICIAN'S NAME (Type) THEODORE H. KAISER							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-8-1958		22c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.		22d. LOCATION (City, town, or county) (State) HAVRE DE GRACE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell ADDRESS Havre de Grace Md.				24a. REG'D BY REGISTRAR MAR 10 1958 DATE		24b. REGISTRAR'S SIGNATURE W. J. ...	

U. S. A.

1951

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03392

3412

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryman				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryman			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Parker Middle Mitchell Last Sr.				4. DATE OF DEATH Month March Day 15 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 Feb. 1874	9. AGE (In years last birthday) 84 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canner		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick O. Mitchell				14. MOTHER'S MAIDEN NAME Eliza McGaw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. 213-28-3102		17. INFORMANT Parker Mitchell Jr.		Address Perryman, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute myocardial infarction 4 years DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Lobar Pneumonia							INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:20AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andre Weiss M.D.				ADDRESS (Street, city or town, state) 17 N. Phila Blvd. DATE SIGNED			
PHYSICIAN'S NAME (Type) Andre Weiss M.D.				Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/58		22c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery		22d. LOCATION (City, town, or county) (State) Perryman Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Farney				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE MAR 19 '58	
				24b. REGISTRAR'S SIGNATURE Al. Lewis			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 19 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22 Film 227 3-31-58 et

3396

CERTIFICATE OF DEATH

Reg. Dist. No.

03393

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wilmington</u> b. COUNTY <u>NEW CASTLE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUCE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 HRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilmington</u> <u>BEACH EX 4</u>			
f. STREET ADDRESS <u>120 Brighton Ave.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>Palandari</u> Last <u>Palandari</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 10. 1902</u>	
9. AGE (In years last birthday) <u>56</u> yrs		IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ITALY</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>PASQUALE GROSSI</u>				14. MOTHER'S MAIDEN NAME <u>MARIA Amoto PASTORE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Alexander Palandari - Beach Wy</u>		Address <u>120 Brighton Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart posterior Coronary thrombosis</u> 420.1 DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 HRS.</u> <u>2 Years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> 19 <u>—</u> p. m. <u>—</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>3/10</u> , 19 <u>58</u> , to <u>3/11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/11</u> , 19 <u>58</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>—</u>				ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u> DATE SIGNED <u>3/11/58</u>			
PHYSICIAN'S NAME (Type) <u>Edmund C. Lee, M.D.</u>				<u>Hauc de Grace, Del.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/15/58</u>		<u>Cathedral</u>		<u>Wilmington Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u>				24a. REGISTRY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **03394**

FOR STATE
HEALTH DEPT

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Hanford		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Md b. COUNTY Hanford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RD 1		4. STREET ADDRESS RD 1	
3. NAME OF DECEASED (Type or print) James E Russell		4. DATE OF DEATH March 9 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 9 - 1889
9. AGE (in years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY FARM	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Dan Thomas Russell		14. MOTHER'S MAIDEN NAME Susanna Shade	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-32-7704	
17. INFORMANT RD 1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic CV disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C Palmer		CHIEF MEDICAL EXAMINER Bel Air, Md	
EXAMINER'S NAME (Type) Gerald C Palmer M.D.		DATE SIGNED 3-9-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 11-58	22c. NAME OF CEMETERY OR CREMATORY Union Chapel	22d. LOCATION (City, town, or county) (State) Wilma Hanford Md
23. FUNERAL DIRECTOR'S SIGNATURE Marion E. G. Garrett		24. REC'D BY REGISTRAR Mar 13 '58	
24b. REGISTRAR'S SIGNATURE Mar 13 '58			

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JAN 10 1964
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3397

CERTIFICATE OF DEATH

03395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>RD # 1</u>			
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>DARE</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 4, 1907</u>	
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOILER FIREMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BAINBRIDGE</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Smith</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Haynes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>214-16-3193</u>		17. INFORMANT Address <u>ERNEST D. SMITH JR. CONYOWIN MC. MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334x</u> DUE TO <u>Coronary infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 11, 1958</u> to <u>March 21, 1958</u> , that I last saw the deceased alive on <u>20 March 1958</u> , and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward J. Simon</u> M.D.				DATE SIGNED <u>March 21, 1958</u>			
PHYSICIAN'S NAME (Type) <u>EDWARD J. SIMON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar 25/58</u>		<u>Brookview Cem</u>		<u>Rising Sun, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Earl Tyson</u>				ADDRESS <u>Rising Sun, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 23 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u> </u>	

RECEIVED

MAR 26 1938

BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3398

CERTIFICATE OF DEATH

Reg. Dist. No.

03396

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>MD.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>	
c. LENGTH OF STAY IN 1b <u>LIFE</u>		d. STREET ADDRESS <u>638 N. Stokes ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>M.</u> Last <u>Smith.</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-10-58</u>
9. AGE (In years last birthday) yrs. <u>—</u>		IF UNDER 1 YEAR: Months <u>1</u> Days <u>6</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kenneth Smith</u>		14. MOTHER'S MAIDEN NAME <u>Murtle Smith (Simmons)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Kenneth W. Smith</u>		Address <u>638 N. Stokes St.</u> City <u>MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u> <u>SIX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RETROPERITONEAL ABSCESS</u> DUE TO (c) <u>Origin of (a) unknown.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that I attended the deceased from <u>Feb 10</u> , 19 <u>58</u> , to <u>March 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 16</u> , 19 <u>58</u> , and that death occurred at <u>10:00 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Beulah D. Hill</u>		ADDRESS (Street, city or town, state) <u>HARRE-DE-GRACE, MD.</u> DATE SIGNED <u>3/17/58</u>	
PHYSICIAN'S NAME (Type) <u>GUNTHER D. HIRSCH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-19-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>HARRE-DE-GRACE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>Harre-de-Grace Md.</u>	
24a. REC'D BY REGISTRAR <u>—</u> DATE <u>MAR 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

BUREAU X, 21

DEPT. OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3414

Items 8 of File 1227 3-31-58 et
CERTIFICATE OF DEATH

Reg. Dist. No.

03397

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen, R.D. #2				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Albert Last Stansbury				4. DATE OF DEATH Month March Day 10 Year 1958			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 Feb. 1904	
9. AGE (In years last birthday) 54		10. IF UNDER 1 YEAR Months 5 Days 50 Hours 50 Min		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Foreman				10b. KIND OF BUSINESS OR INDUSTRY Railroad (APG.)			
13. FATHER'S NAME John W. Stansbury				14. MOTHER'S MAIDEN NAME Mary Pitt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Chas. E. Stansbury R.D. 1 Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition DUE TO Abdominal Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 6-5-1950 to 3-10-1958 , that I last saw the deceased alive on 3-10-1958 , and that death occurred at 7:30 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8 Law Street DATE SIGNED ACTUAL SIGNATURE Peter P. Rodman M.D. PHYSICIAN'S NAME (Type) Peter P. Rodman M.D. Aberdeen, Md. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 3/14/58 22c. NAME OF CEMETERY OR CREMATORY Union Methodist 22d. LOCATION (City, town, or county) (State) Aberdeen, Md. 23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring ADDRESS Aberdeen, Md. 24a. REC'D BY REGISTRAR MAR 14 58 DATE 24b. REGISTRAR'S SIGNATURE W. H. Beach							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 14 1958

BUREAU V. S.

3415

CERTIFICATE OF DEATH

Reg. Dist. No. 03398

1. PLACE OF DEATH o COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen R.D.				c. LENGTH OF STAY IN 1b 46 yrs.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ernest Middle Last Stein				4. DATE OF DEATH Month March , Day 15 , Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1880		9. AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Home Construction		11. BIRTHPLACE (State or foreign country) Baltimore, Md.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter R. Stein				14. MOTHER'S MAIDEN NAME Carrie Bloomier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-32-8351		17. INFORMANT Mamie Stein Address Aberdeen, R.D., Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basal Cell Carcinoma - stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from Aug , 1957, to March , 1958, that I last saw the deceased alive on March 14, 1958 , and that death occurred at 1 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Churchville, Md DATE SIGNED March 18							
ACTUAL SIGNATURE T. Ralph Horky		M.D. Churchville, Md					
PHYSICIAN'S NAME (Type) T. Ralph Horky		Churchville, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 18, 1958	22c. NAME OF CEMETERY OR CREMATORY Baker's		22d. LOCATION (City, town, or county) (State) Aberdeen, Harford, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Williams Jr		ADDRESS Abingdon, Maryland.		24a. REC'D BY REGISTRAR DATE MAR 21 '58	24b. REGISTRAR'S SIGNATURE W. H. Beach		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. BUREAU

850-108

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

3416

03399

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Kalmia		7 months		TOWN North East			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Rd. # 1, Bel Air							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
George W. Stewart				March 24 19 58			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED,	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Widowed	July 9, 1871	86 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Textile Weaver		Retired		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
J. Thomas Stewart				Annie Cownden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO				James Stewart, Rd. #1, Box 238, Bel Air, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Uremia						2 Weeks	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						?	
STATING UNDERLYING CAUSE LAST. DUE TO							
(C) Chronic cardio-vascular-renal disease						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from October 30 19 57 to March 24 19 58 , that I last saw the deceased alive on March 23 19 58 , and that death occurred at 9:20 P. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Willard P. Hudson				M.D. Forest Hill, Maryland		March 25, 1958	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		March 27, 1958		Methodist Cemetery		North East, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
MAR 27 '58		W. P. Hudson		Joseph W. Foster		Bel Air Maryland	
DATE							

RECEIVED

MAR 1 3

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03400

3417

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Black Horse Rural</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Hall Monkton RD md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Har. Co. Convalescing Home</i>		d. STREET ADDRESS <i>RD 7</i>	
3. NAME OF DECEASED (Type or print) <i>Benjamin Horvey Sutton</i>		4. DATE OF DEATH Month <i>March</i> Day <i>22</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-9-22-1868</i>
9. AGE (In years last birthday) <i>89</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>7</i> Hours <i>7</i> Min.	IF UNDER 24 HRS Hours <i>7</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Co md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Elbridge Sutton</i>		14. MOTHER'S MAIDEN NAME <i>Sarah E. Noremaker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>---</i>	
17. INFORMANT <i>Mrs Gertrude Dosh, Monkton RD</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic & V disease</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1-1</i> 19 <i>58</i> to <i>3-22</i> 19 <i>58</i> , that I last saw the deceased alive on <i>3-22</i> 19 <i>58</i> , and that death occurred at <i>2A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Gerald C Palmer</i> M.D.		ADDRESS (Street, city or town, state) <i>Bel Air, Md.</i> DATE SIGNED <i>3-24-58</i>	
PHYSICIAN'S NAME (Type) <i>Gerald C Palmer MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>March 25-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>West Liberty</i>	22d. LOCATION (City, town, or county) (State) <i>White Hall RD md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Martin E. Hunt</i>		24. REC'D BY REGISTRAR DATE <i>MAR 27 '58</i>	
ADDRESS <i>Jamesville</i>		24b. REGISTRAR'S SIGNATURE <i>W. E. Eason</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAR 24 1953

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03401

FOR STATE
HEALTH DEPT.

3399

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) b. STATE Maryland b. COUNTY Harford Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) First FANE Middle Last TAPP		4. DATE OF DEATH Month March Day 2 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/13/1913
9. AGE (In years last birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 710MC Laborer	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S. H.	
13. FATHER'S NAME Frank T. Tapp		14. MOTHER'S MAIDEN NAME Evelyn Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes World War 2		16. SOCIAL SECURITY NO. 218-18-3721	
17. INFORMANT Marion Tapp		Address Pert Deposit, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost, (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/3/58	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/58	
22c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		22d. LOCATION (City, town, or county) (State) Port Deposit R.D. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lea Patterson Son		24a. REC'D BY REGISTRAR WARR 5 '58	
ADDRESS Perryville, Md.		24b. REGISTRAR'S SIGNATURE WARR 5 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

1873

RECEIVED

Reg. Dist. No. 03402

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and return event within 72 hours after death.

VS. AISME
SM 2/57

1. PLACE OF BIRTH a. COUNTY <u>Harford</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harred-Grace</u>		c. LENGTH OF STAY IN Ia <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. STREET ADDRESS <u>Maynoia</u>	
3. NAME OF DECEASED (Type or print) <u>Raymond E. Tester</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-12</u>
9. AGE (In years last birthday) <u>46 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>OLLIE Testerman</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Ball</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Raymond Testerman, Pearl Bottom</u>		Address <u>Harford</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound fracture skull</u> DUE TO (b) <u>Blow</u> DUE TO (c) <u>Interval between onset and death 16 hours</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto-pedestrian</u>	
20c. TIME OF INJURY Month, Day, Year <u>3-28 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US 40</u>		20f. (City or town) (County) (State) <u>Joppa Harford</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E. Palmer</u>		DATE SIGNED <u>3-29-58</u>	
EXAMINER'S NAME (Type) <u>Gerald E. Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 1, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Penn Hill Friends Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pearl Bottom Lane, Co. Harford</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reynolds</u>		ADDRESS <u>Quarryville Pa</u>	
24a. REC'D BY REGISTRAR <u>APR 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Reynolds</u>	

BUREAU V. S.

APR 1 1948

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial/transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3418 **CERTIFICATE OF DEATH**

03403

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Edgewood</u>		LENGTH OF STAY (in this place) <u>7 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>O.P.D. ACC, Edgewood, Md.</u>				STREET ADDRESS (If rural give location) <u>15 E. Cedar Drive</u>			
3. NAME OF DECEASED (Type or Print) <u>Ralph</u> (First) <u>F.</u> (Middle) <u>Tropea</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 18</u> <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>10 June 1954</u>	9. AGE last birthday <u>3</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days		IF UNDER 24 HRS. Hours <u>9</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ralph F. Tropea Jr</u>				14. MOTHER'S MAIDEN NAME <u>Hara Shizuko xmi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>0</u>		17. INFORMANT'S ADDRESS <u>Father</u> <u>15 E. Cedar Drive Edgewood, Md.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>BILATERAL PNEUMONIA</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Measles</u>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>0</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>0</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 15, 1958</u> to <u>Mar. 15, 1958</u> , that I last saw the deceased alive on <u>Feb. 28, 1958</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>ACC, Edgewood, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/25/58</u>		NAME OF CEMETERY OR CREMATORY <u>Post Cemetery</u>		LOCATION (City, town, or county) (State) <u>Army Chemical Center, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>MAR 27 '58</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Aberdeen, Md.</u>	

RECEIVED

MAR 19 1911

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03404

3419 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Street</i>		LENGTH OF STAY (In this place) <i>Lifetime</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Street</i>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>R.F.D. #2 Box 115</i>				STREET ADDRESS (If rural give location) <i>R.F.D. #2 Box 115</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>MILTON</i> (Middle) <i>C.</i> (Last) <i>WATTERS</i>				(Month) <i>MARCH</i> (Day) <i>5</i> (Year) <i>1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>1-22-1905</i>	9. AGE last birthday <i>53</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
						Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Lock Port Pipe Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Walter Watters</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Kenly</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>218-07-0458</i>		17. INFORMANT & ADDRESS <i>R.F.D. #2 Box 115 Street</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
100X IMMEDIATE CAUSE (A) <i>Carcinoma of Esophagus ?</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> N. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/8/58</i> , 19 <i>58</i> , to <i>3/5/58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>2/27/58</i> , 19 <i>58</i> , and that death occurred at <i>5:30 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Ruth Bullock</i>				ADDRESS (Street, city, town, state) <i>Forest Hill, Maryland</i>		DATE SIGNED <i>3/5/58</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3-8-58</i>		NAME OF CEMETERY OR CREMATORY <i>Clark's Chapel Cem</i>		LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
24. REC'D BY REGISTRAR <i>MAR 10 1958</i>		REGISTRAR'S SIGNATURE <i>Alfred...</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Bullock</i>		ADDRESS <i>Home de...</i>	
DATE							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

B. A. OVEY

1894

MADE

CERTIFICATE OF DEATH

Reg. Dist. No.

3420

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DARLINGTON (RURAL)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X DARLINGTON (RURAL)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1 d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BARBARA E WEAVER</u>		4. DATE OF DEATH Month Day Year <u>MARCH 11 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 3, 1957</u>
9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>9 8</u>		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>HARFORD COUNTY, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JACK WEAVER</u>		14. MOTHER'S MAIDEN NAME <u>MARY HONAKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MOTHER, Darlington, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA -</u> <u>299X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRAIN DAMAGE FROM ANEMIA</u> DUE TO (c) <u>RH BLOOD DYSCRASIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u> <u>7 MOS</u> <u>FROM BIRTH</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>AUGUST, 1958</u> , to <u>MARCH 10, 1958</u> , that I last saw the deceased alive on <u>MARCH 10, 1958</u> , and that death occurred at <u>1015AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip W. Henman</u> M.D.		ADDRESS (Street, city or town, state) <u>307 Hickory BELAIR, Md</u>	
DATE SIGNED <u>MARCH 11, 1958</u>			
PHYSICIAN'S NAME (Type) <u>PHILIP W. HENMAN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>March 13, 1958</u>	<u>Welcome Home Cem</u>	<u>Harford Co, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Darlington Md.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <u>MAR 13 1958</u>	<u>DeLoach</u>

2071223XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, place of death, cause of death, and physician's signature.

RECEIVED
MAR 13 1936
BUREAU V. S.

CERTIFICATE OF DEATH

03406

Reg. Dist. No.

3421

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - BELAIR				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - BELAIR			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #1				d. STREET ADDRESS R.D. #1			
3. NAME OF DECEASED (Type or print) First ANNIE Middle Z. Last WILLIAMS				4. DATE OF DEATH Month MAR. Day 17 Year 1958			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-19-1872	9. AGE (In years and birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) LANCASTER Co., Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID E. WILLIAMS				14. MOTHER'S MAIDEN NAME MARY E. HUTTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT Address R.C. WILLIAMS, BELAIR R.D. #1, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO URÆMIA, TERMINAL CARDIAC CONGESTIVE FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS of Old Age (85) (c) 10 years						INTERVAL BETWEEN ONSET AND DEATH 3 wks 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar , 19 57 , to Mar , 19 58 , that I last saw the deceased alive on Mar 10 , 19 58 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE A.I. Sandecki M.D.				ADDRESS (Street, city or town, state) 15 Courtland Street		DATE SIGNED 3.18.58	
PHYSICIAN'S NAME (Type) A.I. SANDECKI M.D.				Bel Air, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-23-58		22c. NAME OF CEMETERY OR CREMATORY SLATEVILLE		22d. LOCATION (City, town, or county) (State) DELTA, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H. Harbins, Delta, Pa.				24a. REC'D BY REGISTRAR MAR 26 '58		24b. REGISTRAR'S SIGNATURE Alfred	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

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CERTIFICATE OF DEATH

BURMAN V. B.

MAR 26 1958

RECEIVED